Washington State Health Care Authority
Public Employees Benefits Board

2013 COBRA Continuation or Extension of Coverage

- **Type or print clearly in black ink.** Inaccurate, incomplete, or illegible information may delay coverage.
- **We must receive your first payment before you can be enrolled.** (Make checks payable to the Washington State Treasurer.)
- List eligible family members you wish to cover or remove from coverage. This form replaces all *COBRA Continuation or Extension of Coverage* forms previously submitted.
- If enrolling a dependent with a disability age 26 or older, or an extended dependent, you must attach the appropriate dependent certification form. Forms are available at **www.pebb.hca.wa.gov** or by calling 1-800-200-1004.

Employee or retiree information only	Employee/retiree name	
	Employee/retiree social security number	Date employer coverage ended (mm/dd/yyyy)

Section 1: Subscriber Information (COBRA Enrollee)

Social security number	Last name	First name	Middle initial	Sex ❑ M ❑ F

Street address	Apt./unit number	City	State	ZIP Code
Mailing address (if different from above)	Apt./unit number	City	State	ZIP Code

County of residence	Date of birth (mm/dd/yyyy)	Daytime phone number ( )	Homephone number ( )

❑ **Continue coverage:** *(select one)*

❑ Medical and dental ❑ Medical only ❑ Dental only

If you have optional life insurance and wish to continue it, complete and submit the *Group Life Portability Application*. The insurer must receive the form no later than **31 days** after your employer sponsored coverage ends.

❑ **Cancel coverage**

Reason_____ Cancel date_____

I understand that I am forfeiting all further rights to enroll in PEBB benefits unless I regain eligibility.

Are you covered by another group medical plan? ❑ Yes ❑ No If yes, effective date_____

Are you covered by another group dental plan? ❑ Yes ❑ No If yes, effective date_____

Are you disabled under Title II (OASDI) of the Social Security Act? ❑ Yes ❑ No If yes, effective date_____

Are you disabled under Title XVI (SSI) of the Social Security Act? ❑ Yes ❑ No If yes, effective date_____

If yes, you must send a copy of your Social Security Disability Award letter.
You and your enrolled dependents may be eligible for additional months of coverage.

Enrolled in Part(s) A and/or B of Medicare? If yes, attach a copy of your Medicare card or entitlement letter to this election form.

Part A (hospital) ❑ Yes ❑ No If yes, effective date_____

Part B (medical) ❑ Yes ❑ No If yes, effective date_____

(continued)

Subscriber's last name	First name	Middle initial	Social security number

Section 2: Spouse or State-Registered Domestic Partner Information

List an eligible spouse or state-registered domestic partner you wish to cover or remove from coverage. Family members cannot be enrolled in two PEBB medical or dental accounts at the same time.

Relationship to subscriber

❑ Spouse: date of marriage_____ ❑ Domestic partner: date registered_____

Social security number	Last name	First name	Middle initial	Date of Birth (dd/mm/yyyy)	Sex ❑ M ❑ F

Street address	Apt./unit number	City	State	ZIP Code

❑ **Continue coverage:** *(select one)*

❑ Medical and dental ❑ Medical only ❑ Dental only

❑ **Cancel coverage**

Reason_____ Cancel date_____

Covered by another group medical plan? ❑ Yes ❑ No If yes, effective date_____

Covered by another group dental plan? ❑ Yes ❑ No If yes, effective date_____

Disabled under Title II (OASDI) of the Social Security Act? ❑ Yes ❑ No If yes, effective date_____

Disabled under Title XVI (SSI) of the Social Security Act? ❑ Yes ❑ No If yes, effective date_____

If yes, you must send a copy of your Social Security Disability Award letter.
You and your enrolled dependents may be eligible for additional months of coverage.

Enrolled in Part(s) A and/or B of Medicare? If yes, attach a copy of your Medicare card or entitlement letter to this form.

Part A (hospital) ❑ Yes ❑ No If yes, effective date_____

Part B (medical) ❑ Yes ❑ No If yes, effective date_____

(continued)

Subscriber's last name	First name	Middle initial	Social security number

Section 3: Family Member Information (such as child) *Use additional forms for more members.*

List eligible family members you wish to cover or remove from coverage. Family members cannot be enrolled in two PEBB medical or dental accounts at the same time. Attach appropriate certification form(s) if enrolling a dependent with a disability age 26 or older, or an extended dependent.

A

Relationship to subscriber	Disabled? ❑ Yes ❑ No *(Check only if age 26 or older.)*	Sex ❑ M ❑ F	Social security number

Last name	First name	Middle initial	Date of birth (mm/dd/yyyy)

Street address (only if different from subscriber) Apt./unit number	City	State	ZIP Code

❑ **Continue coverage:** *(select one)*
❑ Medical and dental ❑ Medical only ❑ Dental only

❑ **Cancel coverage** Reason_____ Cancel date_____

Covered by another group medical plan? ❑ Yes ❑ No If yes, effective date_____

Covered by another group dental plan? ❑ Yes ❑ No If yes, effective date_____

Disabled under Title II (OASDI) of the Social Security Act? ❑ Yes ❑ No If yes, effective date_____

Disabled under Title XVI (SSI) of the Social Security Act? ❑ Yes ❑ No If yes, effective date_____

If yes, you must send a copy of your Social Security Disability Award letter.
You and your enrolled dependents may be eligible for additional months of coverage.

Enrolled in Part(s) A and/or B of Medicare? If yes, attach a copy of your Medicare card or entitlement letter to this form.

Part A (hospital) ❑ Yes ❑ No If yes, effective date_____

Part B (medical) ❑ Yes ❑ No If yes, effective date_____

B

Relationship to subscriber	Disabled? ❑ Yes ❑ No *(Check only if age 26 or older.)*	Sex ❑ M ❑ F	Social security number

Last name	First name	Middle initial	Date of birth (mm/dd/yyyy)

Street address (only if different from subscriber) Apt./unit number	City	State	ZIP Code

❑ **Continue coverage:** *(select one)*
❑ Medical and dental ❑ Medical only ❑ Dental only

❑ **Cancel coverage** Reason_____ Cancel date_____

Covered by another group medical plan? ❑ Yes ❑ No If yes, effective date_____

Covered by another group dental plan? ❑ Yes ❑ No If yes, effective date_____

Disabled under Title II (OASDI) of the Social Security Act? ❑ Yes ❑ No If yes, effective date_____

Disabled under Title XVI (SSI) of the Social Security Act? ❑ Yes ❑ No If yes, effective date_____

If yes, you must send a copy of your Social Security Disability Award letter.
You and your enrolled dependents may be eligible for additional months of coverage.

Enrolled in Part(s) A and/or B of Medicare? If yes, attach a copy of your Medicare card or entitlement letter to this form.

Part A (hospital) ❑ Yes ❑ No If yes, effective date_____

Part B (medical) ❑ Yes ❑ No If yes, effective date_____

(continued)

Subscriber's last name	First name	Middle initial	Social security number

Section 4: Changes to an Existing Account

Are you making changes to an existing account?

❑ **Yes** **If yes, what changes?** *(Check all that apply in the sections below.)*

❑ **No** *If no, go to Section 5 on page 6.*

Changes you can make anytime

Give date of event/change _____

❑ Name change

❑ Address change

❑ Cancel medical coverage

❑ Cancel dental coverage

❑ Remove dependent(s) from coverage. If removing due to loss of eligibility (divorce, dissolution of domestic partnership, death, or other loss of eligibility for PEBB benefits), **you must submit this form no later than 60 days after the event.** If applicable, provide former dependent's new address:

_____

Additional changes you can make during annual open enrollment

All changes become effective January 1 of the following year.

Check the box(es) next to the change requested.

❑ Add dependent(s)

❑ Change medical plan

❑ Change dental plan

(this section continued on next page)

Subscriber's last name	First name	Middle initial	Social security number

Section 4: Changes to an Existing Account *(continued)*

Additional changes you can make if an event creates a special open enrollment

The PEBB Program allows changes outside of an annual open enrollment when an event creates a special open enrollment. The change must be on account of and correspond with an event that affects eligibility for coverage. You may be required to provide proof of the event that created the special open enrollment. **You must submit this form no later than 60 days after the event.** However, if adding a newborn or newly adopted child and the child increases your premium, you must submit this form no later than 12 months after the birth or adoption.

Check the box next to the change(s) you are requesting, and indicate the corresponding event(s) below. See the numbers beside each change to verify your requested change may be allowed.

❑ **Add dependent(s)** (allowable under events 1, 2, 3, 4, 5, 6, 7, 9, 10)

❑ **Change medical and/or dental plan** (allowable under events 1, 2, 3, 4, 5, 8, 9, 10, 11, 12, 13)

Give date of event_____

Check the box(es) next to the corresponding event(s). The event number must be listed next to the requested change(s) above.

❑ 1. Marriage, registering a domestic partner, birth, adoption, or assuming a legal obligation for total or partial support in anticipation of adoption.

❑ 2. Child becoming eligible as an extended dependent through legal custody or legal guardianship. *Also complete an* Extended Dependent Certification *form. Form available at* **www.pebb.hca.wa.gov**.

❑ 3. Child becoming eligible as a dependent with a disability. *Also complete a* Certification of Dependent With a Disability *form. Form available at* **www.pebb.hca.wa.gov**.

❑ 4. Subscriber or dependent losing other coverage under a group health plan or through health insurance, as defined by the Health Insurance Portability and Accountability Act (HIPAA).

❑ 5. Subscriber or dependent having a change in employment status that affects the subscriber's or dependent's eligibility for the employer contribution toward group health coverage.

❑ 6. Subscriber or dependent having a change in enrollment under another employer plan during its annual open enrollment that does not align with the PEBB Program's annual open enrollment.

❑ 7. Subscriber's dependent moving from outside the United States to live within the United States.

❑ 8. Subscriber or dependent having a change in residence that affects health plan availability.

❑ 9. A court order or National Medical Support Notice requires the subscriber or any other individual to provide insurance coverage for an eligible dependent of the subscriber.

❑ 10. Subscriber or dependent becoming eligible or losing eligibility for premium assistance through Medicaid or a state Children's Health Insurance Program (CHIP).

❑ 11. Subscriber or dependent becoming entitled to Medicare, or enrolling in or disenrolling from a Medicare Part D plan.

❑ 12. Subscriber or dependent's current health plan becoming unavailable because the subscriber or dependent is no longer eligible for a health savings account (HSA).

❑ 13. Subscriber or dependent experiencing a disruption of care that could function as a reduction in benefits for the subscriber or his or her dependent for a specific condition or ongoing course of treatment (requires PEBB approval).

Are you or any eligible dependents enrolled in PEBB coverage under another account? ❑ Yes ❑ No

(continued)

Subscriber's last name	First name	Middle initial	Social security number

Section 5: Medical Plan Selection *Check only one.*

Forms are available at www.pebb.hca.wa.gov or by calling 1-800-200-1004.

Contact plans for benefits information; their contact information is at the end of this form.

Group Health Cooperative[1]

- ❑ Group Health Classic
- ❑ Group Health Medicare Plan[2]
- ❑ Group Health Value

Group Health Options Inc.

- ❑ Group Health Consumer-Directed Health Plan[3]

Kaiser Foundation Health Plan of the Northwest

- ❑ Kaiser Permanente Classic
- ❑ Kaiser Permanente Consumer-Directed Health Plan[3]
- ❑ Kaiser Permanente Senior Advantage[1]

❑ **Medicare Supplement Plan F, administered by Premera Blue Cross[4]**

Uniform Medical Plan, administered by Regence BlueShield

- ❑ UMP Classic
- ❑ UMP Consumer-Directed Health Plan[3]

[1] **These plans offer Medicare Advantage plans to Medicare enrollees in certain counties. Complete and attach the *Medicare Advantage Plan Election Form* (form C) if you live in a county where Medicare Advantage is available.**

[2] **If you cover family members not enrolled in Medicare, also select Group Health Classic or Group Health Value for your non-Medicare family members.**

[3] **These plans are available only to retirees not enrolled in Medicare. If you cover a dependent enrolled in Medicare, you must cancel your dependent's PEBB coverage to enroll in this plan.**

[4] **Also complete and return the *Group Medicare Supplement Enrollment Application* (form B) to enroll in Medicare Supplement Plan F. PEBB does not offer the high-deductible Plan F.**

Section 6: Dental Plan Selection *Check only one.*

Contact plans for benefits information; their contact information is at the end of this form.

Preferred Provider Organization

- ❑ Uniform Dental Plan, administered by Washington Dental Service (Group #3000)
  (may receive services from any provider)

Managed-Care Plans

- ❑ DeltaCare, administered by Washington Dental Service (Group #3100)

  Dentist name or clinic code_____
  (must receive services from a DeltaCare provider)

- ❑ Willamette Dental of Washington, Inc.

  Clinic location_____
  (must receive services from a Willamette Dental Group plan provider)

(continued)

2013 COBRA Continuation or Extension of Coverage *(continued)*

Subscriber's last name	First name	Middle initial	Social security number

Section 7: Signature *Required*

I have received and read the *Continuation of Coverage Election Notice* including any appendices. By signing this form, I declare that the information I have provided is true, complete, and correct. If it isn't, or if I do not update this information within the timelines in PEBB rules, to the extent permitted by federal and state law, I must repay any claims paid by my health plan(s). My family members and I may also lose PEBB benefits as of the last day of the month we were eligible. To the extent permitted by law, PEBB may retroactively terminate coverage for me and my dependents if I intentionally misrepresent eligibility, or do not fully pay premiums when due. In addition, I understand that knowingly providing false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company is a crime, and can result in imprisonment, fines, and denial of PEBB benefits.

If adding a domestic partner to my account, I declare that my partner and I have registered through the Washington Secretary of State's Office or another state.

If I send payment, this does not mean that I will be automatically enrolled in PEBB insurance coverage. The PEBB Program will verify eligibility for me and my family members. If we do not qualify, I will receive a refund.

If I am enrolling in a consumer-directed health plan with a health savings account (HSA), I must meet HSA eligibility conditions. I understand that the PEBB Program will direct a portion of my monthly premium to an HSA on my behalf based on the information I have provided, and that there are limits to these contributions and my HSA contributions (if any) under federal tax law.

This form replaces all *COBRA Continuation or Extension of Coverage* forms previously submitted to PEBB.

HCA's Privacy Notice:
We will keep your information private as allowed by law. To receive our Privacy Notice, call 360-725-0442 or go to **www.hca.wa.gov**.

Subscriber's signature_____ **Date** _____

Please sign and date this form.

Mail to:
Washington State Health Care Authority, P.O. Box 42684, Olympia, WA 98504-2684

If payment is enclosed, mail to:
Washington State Health Care Authority, P.O. Box 42695, Olympia, WA 98504-2695

Or hand-deliver to:
Washington State Health Care Authority, 626 8th Ave. SE, Olympia, WA 98501

2013 PEBB MEDICAL CONTRACTORS

Group Health Cooperative, 320 Westlake Ave. N, Suite 100, Seattle, WA 98109-5233
1-888-901-4636 or TTY 1-800-833-6388

Group Health Options Inc., 320 Westlake Ave. N, Suite 100, Seattle, WA 98109-5233
1-888-901-4636 or TTY 1-800-833-6388

Kaiser Foundation Health Plan of the Northwest, 500 NE Multnomah St., Suite 100, Portland, OR 97232-2099
1-800-813-2000 or TTY 1-800-735-2900

Premera Blue Cross, P.O. Box 327, Seattle, WA 98111-0327
1-800-817-3049 or TTY 1-800-842-5357

Uniform Medical Plan, administered by Regence BlueShield, P.O. Box 2998, Tacoma, WA 98401-2998
1-888-849-3681 or TTY 711

2013 PEBB DENTAL CONTRACTORS

DeltaCare, administered by Washington Dental Service, 9706 Fourth Avenue NE, Seattle, WA 98115-2157
1-800-650-1583

Uniform Dental Plan, administered by Washington Dental Service, 9706 Fourth Avenue NE, Seattle, WA 98115-2157
1-800-537-3406

Willamette Dental of Washington, Inc., 6950 NE Campus Way, Hillsboro, OR 97124-5611
1-855-433-6825